QUARTERLY CONTRACT MONITORING REPORT (QCMR)
CLIENT MOVEMENT REPORT
PARTIAL CARE SERVICES

USTF PROJECT CODE:	**REPORTING QUARTER: (CHECK ONE):**	
NAME OF AGENCY:	**JULY 1 TO SEPTEMBER 30**	**1** ☐
NAME OF PROGRAM:	**OCTOBER 1 TO DECEMBER 31**	**2** ☐
PERSON COMPLETING FORM/PHONE #:	**JANUARY 1 TO MARCH 31**	**3** ☐
DATE SUBMITTED:	**APRIL 1 TO JUNE 30**	**4** ☐

CHECK AGENCY REPORTING QUARTER: →	**1** ☐	**2** ☐	**3** ☐	**4** ☐

1.	**2.**	**3.**	**4.**	**5.**	**6.**
Beginning Active Caseload (First Day of Qtr.)	**New Enrollees to Program Element During Qtr.**	**Transfers to Program Element During Qtr**	**Transfers From Program Element During Qtr**	**Terminations From Program Element During Qtr.**	**Ending Active Caseload (Last Day of Qtr.)**

TARGET GROUPS		**7. Number of Target Group Members:**	
		NEW ENROLLEES	**TRANSFERS**
7A.	**Clients who were Discharged from State Hospitals and Enrolled in this Program Within 30 Days of Discharge.**		
7B.	**Clients who were Discharged from County Hospitals and Enrolled in this Program Within 30 Days of Discharge.**		
7C.	**Clients who were Discharged from a Short-Term Care Facility/Involuntary Psychiatric Unit and Enrolled in this Program within 30 Days of Discharge.**		
7D.	**Clients who were Discharged from another Hospital and Enrolled in this Program Within 30 Days of Discharge.**		

CLIENT MOVEMENT REPORT

BEGINNING ACTIVE CASELOAD: Consist of clients who have had at least one face-to-face contact with your agency in the last 90 days and were active on the last of the previous quarter. **The Beginning Caseload is equal to the Ending Caseload of the previous reporting quarter.**

NEW ENROLLEES: Clients who were newly enrolled in your agency during the reporting quarter and were enrolled in this program element prior to enrollment in any other program element within your agency.

TRANSFERS TO: Refers to clients who are already registered within your agency in another program element, and are being transferred to this program element service.

TRANSFERS FROM: Refers to clients who are registered within your agency in this program element, but for whom this program has ceased to provide services on an ongoing basis and for whom another program element of your agency is going to provide services on an ongoing basis.

TERMINATIONS: Clients who are no longer receiving services at your agency.

ENDING ACTIVE CASELOAD: Is the active caseload on the last day of the reporting quarter. It is calculated in the following manner: **Add #1** (Beginning Active Caseload) **+ #2** (New Enrollees) **+ #3** (Transfers To). **Subtract #4** (Transfers From) and **#5** (Terminations) = **Ending Caseload #6**.

DUPLICATED COUNT OF TARGET GROUP MEMBERS AMONG "NEW ENROLLEES" AND "TRANSFERS TO": Refers to the count of clients who entered this program element within 30 days of their discharge from the hospital. The definitions of "New Enrollees" and "Transfers To" are the same as stated above. Therefore, the number of "New Enrollees" or Transfers To" indicated in categories 7A, 7B, 7C, and 7D, should be the same or less than the number indicated in items #2 and #3 of this form.

7A. STATE HOSPITAL: Refers to the states six psychiatric hospitals located in New Jersey only: Greystone Park, Trenton, Ancora, Arthur Brisbane, Hagedorn, and Ann Klein.

7B. COUNTY HOSPITALS: Refers to the six county hospitals located in New Jersey only: Essex, Burlington, Camden, Hudson, Bergen, and Union.

7C. SHORT-TERM CARE FACILITIES: Refers to inpatient, community-based mental health treatment facilities that provide acute care and assessment services to the mentally ill. The Commissioner, Department of Human Services must designate the facility.

7D. OTHER HOSPITAL: Refers to any psychiatric hospital or psychiatric unit within a hospital that is not a State, County or STCF Hospital in New Jersey; include as "Other" any Facility located outside of New Jersey.

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LEVEL OF SERVICE REPORT
PARTIAL CARE SERVICES

USTF PROJECT CODE:	**REPORTING QUARTER: (CHECK ONE)**
NAME OF AGENCY:	**JULY 1 TO SEPTEMBER 30** 1 ☐
NAME OF PROGRAM:	**OCTOBER 1 TO DECEMBER 31** 2 ☐
PERSON COMPLETING FORM/PHONE #:	**JANUARY 1 TO MARCH 31** 3 ☐
DATE SUBMITTED:	**APRIL 1 TO JUNE 30** 4 ☐

CHECK AGENCY REPORTING QUARTER: →	**1** ☐	**2** ☐	**3** ☐	**4** ☐

INFORMATION RELATED TO ENROLLED CLIENTS

1. Of the Ending Caseload for ***Regular PC/PH*** , how many clients are:

   A. Medicaid/Familycare Enrolled ☐ B. Medicaid/Familycare Non-Enrolled ☐
   (1A. + 1B. must equal TotalRegualr PC/PH ending caseload)

2. Of the Ending Caseload for ***Acute PH*** , how many clients are:

   A. Medicaid/Familycare Enrolled ☐ B. Medicaid/Familycare Non-Enrolled ☐
   (2A. + 2B. must equal Total Acute PH ending caseload)

	Regular PC/PH	Acute PH
3. Average Daily Attendance	☐	☐
4. Physical Client Capacity	☐	☐
5. Total Units of Service	☐	☐

6. Of the Total ***Regular PC/PH*** Units of Service Provided how many were provided to individuals who were:

   A. Medicaid/Familycare Enrolled ☐ B. Medicaid/Familycare Non-Enrolled ☐
   (6A. + 6B. must equal Total Regular PC/PH Units of Service)

7. Of the Total **Acute *PH*** Units of Service Provided how many were provided to individuals who were:

   A.Medicaid/Familycare Enrolled ☐ B. Medicaid/Familycare Non-Enrolled ☐

   (7A. + 7B. must equal Total Acute /PH Units of Service)

PARTIAL CARE SERVICES

Comprehensive, facility-based, structured, non-residential day treatment mental health services that may reduce the risk of hospitalization and that may include structured support, rehabilitation, relapse prevention, and/or the development of community living skills. Services may include counseling, psychoeducation, medication monitoring and other psychiatric care, prevocational training, direct skills teaching, and recreation and social events, available on a half-day or full-day basis for no fewer than five days per week.

UNITS OF SERVICE: Refers to the total count of units of service provided to all partial care clients. The definition of a unit of service is 1 hour = 1 unit; e.g. client attends for 2 hours of partial care services = 2 units of service.

PHYSICAL CLIENT CAPACITY: Refers to the space in which the PC/PH is located as limited by legal constraints such as fire codes, as well as what capacity the provider would feel comfortable serving, were resources made available to fund this capacity.

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SERVICES RELATED TO ENROLLED CLIENTS OR UNENROLLED INDIVIDUALS

8. Number of Staff Face-to-Face Outreach Contacts Provided with Individuals Residing in:

   A. Independent Living Arrangements ____

   B. Boarding Homes ____

   C. Nursing Homes ____

SERVICES RELATED TO UNENROLLED INDIVIDUALS

9. Number of Residents of State of County Psychiatric Hospitals that:

   A. Participated on-site in the program to prepare for discharge. ____

   B. Were served by your staff at the hospital to prepare for discharge. ____

10. Number of Socialization/Recreation Group Sessions for Former or Inactive Partial Care Clients. ____